STATEMENT OF LICENSING DEFICIENCIES AND PLAN OF CORRECTION revised 9/19/02

Name of Facility:
Facility ID #:
Administrator:
Address: City: Zip:
Phone Number:

Surveyor:
Facility Type:
Date/s of Survey:
Task Order #:
Type of Survey: [*Licensure/Complaint***]**

DEFICIENCY	PLAN OF CORRECTION	COMPLETION DATE

Return completed ***Plan of Correction*** to:
DPHHS Division of Quality Assurance
Licensure Bureau
2401 Colonial Drive, 2nd Floor
P.O. Box 202953
Helena, Montana 59620-2953*

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SIGNATURE_____Title_____Date_____